EMPLOYEE CONFIDENTIALITY AGREEMENT

I, _____, have read and understand the State of Kansas Health Plan policies regarding the privacy of protected health information (PHI), as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In addition, I acknowledge that I have received training in _____ policies concerning PHI use, disclosure, storage and destruction as required by HIPAA.

In consideration of my employment or compensation from the State of Kansas, I hereby agree that I will not at any time – either during my employment or association with the State of Kansas or after my employment or association ends – use, access or disclose PHI to any person or entity, internally or externally, except as is required and permitted in the course of my duties and responsibilities with the State of Kansas, as set forth in _____ _____ privacy policies and procedures or as permitted under HIPAA. I understand that this obligation extends to any PHI that I may acquire during the course of my employment or association with the State of Kansas, whether in oral, written or electronic form and regardless of the manner in which access was obtained.

I understand and acknowledge my responsibility to apply _____ _____ policies and procedures during the course of my employment or association. I also understand that unauthorized use or disclosure of PHI will result in disciplinary action, up to and including the termination of employment or association with the State of Kansas and the imposition of civil penalties and criminal penalties under applicable federal and state law, as well as professional disciplinary action as appropriate.

I understand that this obligation will survive the termination of my employment or end of my association with the State of Kansas, regardless of the reason for such termination.

Signed _____ Date _____